Patient Consent Form – Confidentiality Agreement

Privacy of your personal information is important to Back-to-Back Inc. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate use and protection of your information.

Our privacy policy outlines what Back-to-Back Inc is doing to ensure that:

- Only necessary information is collected about you
- We only share your information with your consent
- Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols
- Our privacy protocols comply with privacy legislation and standards of our regulatory body, the College of Naturopathic Physicians of British Columbia

How our clinic collects, uses and discloses personal patient information:
Back-to-Back Inc. understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined how Back-to-Back Inc. will use and disclose information. The clinic will collect, use and disclose information about you for the following purposes:

- To assess your health concerns and provide health care
- To advise you of treatment options
- To establish and maintain contact with you
- To remind you of upcoming appointments
- To communicate with other treating healthcare providers
- To allow us to efficiently follow-up for treatment, care and billing
- To complete claims for insurance purposes
- To comply with legal and regulatory requirements of our regulatory body, the College of Naturopathic Physicians of British Columbia, acting under the authority of the Health Professions Act
- To invoice for goods and services and to process credit card payments
- To assist this clinic to comply with all regulatory requirements
- To comply generally with the law

By signing the consent section of this Patient Consent form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information as outlined above.

I have reviewed the above information that explains how Back-to-Back Inc. will use my personal information, and the steps Back-to-Back Inc. is taking to protect my information. I agree that Back-to-Back Inc. can collect, use and disclose personal information as set out above in the information about the Back-to-Back's privacy policies.

Print Name Signature Date

PATIENT INTAKE FORM

General Information
Patient name:_____ Date: _____
Date of birth:_____/_____/_____ (M/D/Y) Age: _____ Sex: M / F
Address:_____

Telephone number: Home:_____ Work:_____
E-mail address: _____ Cell: _____
Emergency contact Name: _____
Phone number: _____ Relation: _____

How did you hear about the Clinic?

Brochure	Yellow Pages	Family Doctor	BCNA
Television	Friend	Chiropractor	Directory
Radio	Relative	Specialist	Newspaper
Internet	Coworker	Health Professional	Health Food Store
Other:			

Other health care providers you are seeing:
1. _____
2. _____
3. _____
4. _____
5. _____

Please list your health concerns, in order of importance to you:
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

What long-term expectations do you have from working with our clinic?

What expectations do you have of me personally as your physician?

What is your present level of commitment to address any underlying causes of your signs/symptoms that relate to your lifestyle?

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (Please list)

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits? (Please list)

What potential obstacles do you foresee in addressing the lifestyle factors, which are undermining your health and in adhering to the therapeutic protocols, which we will be sharing with you?

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

Medical History

Describe your general state of health:	Excellent ◯	Good ◯	Fair ◯	Poor ◯

Please indicate all past or current medical conditions, previous illnesses, injuries and or hospitalizations. Include approximate dates.

Do you have any allergies (medications, environmental, foods etc.)?

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, Chinese patents etc.)

Have you ever had any adverse reactions to any medication, supplement, herb or Homeopathic?

Please list all past prescription medications, why you were taking them and for how long.

How many times have you been treated with antibiotics? _____

Female Patients
Are you currently pregnant? Yes / No
When was your last pap? _____ Have you ever had an abnormal pap? Y / N
When was your last breast exam? _____
What is your method of birth control? _____

Do you frequently use any of the following?
Alcohol—how much/day or week: _____
Tobacco—form and amount/day: _____
Caffeine—form and amount/day: _____
Recreational drugs—what and how often: _____

Please indicate what immunizations you have had:

- ☐ DPT (diphtheria, pertussis, tetanus)
- ☐ Haemophilus
- ☐ Hepatitis A
- ☐ Influenza B
- ☐ Tetanus booster; when? _____
- ☐ "Flu"
- ☐ Hepatitis B
- ☐ MMR (measles, mumps, rubella)
- ☐ Polio
- ☐ Smallpox

Please indicate if any caused adverse reactions: _____

Diet

Do you have any food allergies or intolerances? What are your symptoms? Please list.

Do you have any dietary restrictions (religious, vegetarian, vegan, etc.)?

Describe a typical day's diet:
Breakfast _____
Lunch _____
Dinner _____
Snack _____

Family History

Indicate if a relative or family member has had any of the following:

		Who?			Who?
Allergies	☐		Cancer	☐	
Asthma	☐		Diabetes	☐	
Heart disease	☐		Drug abuse /alcoholism	☐	
High blood pressure	☐		Depression	☐	
Stroke	☐		Other mental illness	☐	
Kidney disease	☐		Other		

☐ I don't know my family medical history

Environment

Occupation _____
Hobbies_____
___ Do you exercise regularly? Yes ◯ / No ◯
What do you do for exercise, how much, how often? _____
_____

Are you exposed to significant tobacco smoke (work, home, etc.)? Y / N
Are you frequently exposed to animals? Yes ◯/ No ◯
How old is your house? _____
How is your home heated? _____
Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)?
Please describe? _____
_____

How would you describe the emotional climate of your home?
_____
_____

Do you have someone in your life you can talk to about your emotions? Family or friends whom are a support network? Y / N Whom? _____

Please rate your stress level: (Low) 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ (High)

How do you handle these stresses?
_____
_____

Have you ever experienced anything in your life that was traumatic to you? If you are able to comment on it, please write down a few points?

Is there anything that you feel is important that has not been covered?